

Statement of Citizenship or Identity of Applicant or Recipient

(Form 234C, Instructions)

Purpose: To document an applicant or recipient's claim of citizenship or identity.

Distribution: Original - Case record

Instructions:

1. Enter the name of the applicant or recipient.
2. Enter the name of the payee (this is the parent, guardian or adult in the household).
3. Enter the name of person making the statement.
4. Enter the relationship of the person making the statement to the applicant or recipient.
5. Indicate if the person making the statement is a citizen.
6. Check the block if the statement provides proof of citizenship of the applicant or recipient.
7. Indicate the place of birth (city, state and county) of the applicant or recipient.
8. Indicate the date of birth of the applicant or recipient.
9. Indicate how the person making the statement has personal knowledge of circumstances of the applicant or recipient's claim of citizenship.
10. Indicate why the applicant or recipient cannot provide proof of citizenship and how the person making the statement knows this to be true..
11. For Medicaid use only.
Indicate if there is proof of citizenship and/or identity for the person making the statement.
(You will use the 5 charts for citizenship and identity and attach copies of the proof.)
12. Check the block if the following statement(s) provide proof of identity for a child or children under age 16. (Proof of citizenship and identity is not required for the person attesting to the identity of a child.)
13. Indicate the name of up to three (3) children.
14. Indicate the place of birth of the child (city, state, and county).
15. Indicate the date of birth of the child.
16. Person making statement must sign and enter his or her address, the date the form is signed, and a telephone number.

Statement of Citizenship or Identity of Applicant or Recipient

Name of Applicant or Recipient _____ **(1)**

Payee Name _____ **(2)**

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Name of Person Making Statement _____ **(3)**

Relationship to Applicant or Recipient _____ **(4)**

*I am a U.S. Citizen ☐ Yes ☐ No **(5)**

☐ Statement of Citizenship **(6)**

Understanding that this statement is for a right to payment of Medicaid benefits by Alabama Medicaid Agency, I hereby state under penalty of perjury that I have knowledge that the applicant/recipient **is** a United States citizen. The applicant/recipient was born in: _____ **(7)**, on _____ **(8)**.

(City, State, and County)

(Date of Birth)

I know this to be true because _____ **(9)**

The reason that the applicant/recipient can not provide proof of citizenship is
_____ **(10)**

I know this to be true because _____

Sign on Back

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For Medicaid Use Only: (11)

*Proof of citizenship provided ☐ Yes ☐ No // Proof of identity provided ☐ Yes ☐ No

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☐ Statement of Identity for a Child under age 16 **(12)**

1. I hereby state under penalty of perjury that I have knowledge of this child's identity.

This child, **(13)** ,

(Name of Child)

was born in **(14)** , on **(15)** .

(City, State, and County)

(Date of Birth)

2 I hereby state under penalty of perjury that I have knowledge of this child's identity.

This child, **(13)** ,

(Name of Child)

was born in **(14)** , on **(15)** .

(City, State, and County)

(Date of Birth)

3 I hereby state under penalty of perjury that I have knowledge of this child's identity.

This child, **(13)** ,

(Name of Child)

was born in **(14)** , on **(15)** .

(City, State, and County)

(Date of Birth)

I understand that anyone who knowingly makes a false statement or misrepresents material facts in an application to determine eligibility for Medicaid may be committing a crime punishable under Federal or State law, or both. In signing this statement, I affirm under penalty of perjury that all information I have given in this document is true.

Signature of Person Making Statement

(16)

Signature (First name, middle initial, last name) (Sign in ink) :

Mailing Address (Number and Street, Apt. No., P.O. Box, Rural Route) City, State and Zip Code

Date

Telephone Number

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